Miriam Hospital
The RISE Clinic
14 Third St.
Providence, RI 02906
(401) 793-2427
(401)793-2266 Fax
TB Clinic Referral

DATE OF APPT:

_____

TIME : _____

REFFERING PHYSICIAN:

_____

ADDRESS: _____

TEL #: _____

MEDICAL INSURANCE INFO.

COVERAGE: _____

POLICY #_____

PCP NAME & TEL # _____

_____

PLEASE FAX COPY OF INSURANCE CARD

PLEASE CALL FOR AN APPOINTMENT BEFORE FAXING THIS REFERRAL

Name		**Referral Source**	
Address		**Completed by:**	
		Phone # ( )	
Male: _____ Female: _____		**Primary Language** (please circle one) **Interpreter Needed?**	
Phone ( )		English Vietnamese Portuguese	
DOB:		Spanish Cambodian Laotian	
Reason for Referral:		**Other (specify)**	
+ PPD	suspect active	contact to active	other:
Mantoux Skin Test:	date planted	date read	size
	/ /	/ /	
Previous Mantoux	date planted	date read	size
	/ /	/ /	
CXR (circle response)	yes	no	
If yes :	date / /	place	reading

(please attach chest x-ray report)

Medical Hx of:	diabetes	chronic renal failure	cancer
Immunosuppressive dx		asthma	COPD

Hepatitis (please send hepatitis reports and LFT's, if available)

Is patient pregnant? yes no n/a

If yes please specify expected due date: / /

Comments: